

SENATE BILL 1213

By Yarbro

AN ACT to amend Tennessee Code Annotated, Title 10,
Chapter 7 and Title 56, relative to the reporting of
certain health insurance information.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 2, Part 1, is amended by
adding the following language as a new section:

(a) As used in this section, unless the context otherwise requires:

(1) "Employer" means:

(A) Any person acting directly as an employer, or indirectly in the
interest of an employer, in relation to an employee benefit plan; and

(B) Includes a group or association of employers acting for an
employer in relation to an employee benefit plan;

(2) "Governmental entity" means a state agency or political subdivision of
this state;

(3) "Group health plan":

(A) Means an employee welfare benefit plan as defined in the
federal Employee Retirement Income and Security Act of 1974 (ERISA)
(29 U.S.C. § 1002(1)); and

(B) Includes an insured plan or self-insured plan to the extent that
either plan provides medical care as defined in the federal Public Health
Service Act (42 U.S.C. § 300gg-91(a)(2)), including items and services
paid for as medical care to employees or their dependents directly or
through insurance, reimbursement, or otherwise, that:

(i) Has fifty (50) or more participants as defined in the federal Employee Retirement Income and Security Act of 1974 (ERISA) (29 U.S.C. § 1002(7)); or

(ii) Is administered by an entity other than the employer that established and maintains the plan;

(4) “Health benefit plan issuer” means a health insurance issuer or a health maintenance organization;

(5) “Health insurance issuer” means a health insurance issuer as provided in 45 CFR § 160.103;

(6) “Health maintenance organization” means:

(A) A federally qualified health maintenance organization, as defined by 42 U.S.C. § 300e(a); or

(B) An organization recognized by § 56-32-102, as a health maintenance organization;

(7) “Plan” means an employee welfare benefit plan as defined by 29 U.S.C. § 1002(1);

(8) “Plan administrator” means an administrator as defined by 29 U.S.C. § 1002(16)(A);

(9) “Plan sponsor” means a sponsor as defined by 29 U.S.C. § 1002(16)(B);

(10) “Political subdivision” means a county, municipality, or their instrumentalities; and

(11) “Protected health information” means individually identifiable health information as defined by 45 CFR § 160.103.

(b) This section applies to a governmental entity that enters into a contract with a health benefit plan issuer that results in the health benefit plan issuer delivering, issuing for delivery, or renewing a group health plan. For the purposes of this section, a health

benefit plan issuer shall treat the governmental entity as a plan sponsor or plan administrator.

(c) No later than thirty (30) days after a health plan issuer receives a written request for a written report of claim information from a plan, plan sponsor, or plan administrator, the health benefit plan issuer shall provide the requesting party a written report of claim information as described in subsection (d).

(d) A written report of claim information shall contain all the information available to the health benefit plan issuer that is responsive to the request made pursuant to subsection (c), including protected health information, for the thirty-six-month period preceding the date of the request or for the entire period of coverage, whichever is shorter. A report provided pursuant to subsection (c) shall include:

(1) The aggregate paid claims experience by month, including claims experience for medical, dental, and pharmacy benefits, as applicable;

(2) The total premiums paid by month; and

(3) The total number of covered employees on a monthly basis by coverage tier, including whether coverage was for:

(A) An employee only;

(B) An employee with dependents only;

(C) An employee with a spouse only;

(D) An employee with spouse and dependents; and

(E) A separate description of any claim exceeding ten thousand dollars (\$10,000), including the following information related to the claim:

(i) A unique identifying number, characteristic, or code;

(ii) The amounts paid;

(iii) Dates of service;

(iv) Applicable diagnosis codes; and

(v) Prognosis, or if not available, case management notes, including any future expected costs and treatment plan, that relate to the claim.

(e) A written report of claim information described in subsection (d) shall include the total dollar amount of claims pending as of the date of the report that were first filed during the twenty-four-month period preceding the date of the request or for the entire period of coverage, whichever is shorter.

(f) A written report of claim information provided under this section to a governmental entity is confidential and exempt from public records disclosure under title 10, chapter 7.

(g) A plan sponsor is entitled to receive protected health information under this section only after an appropriately authorized representative of the plan sponsor makes the following certification to the health benefit plan issuer:

“I hereby certify that the plan documents comply with the requirements of 45 CFR § 164.504(f)(2) and that the plan sponsor will safeguard and limit the use and disclosure of protected health information that the plan sponsor may receive from the group health plan to perform the plan administration functions.”

(h) If a request is received by a health plan issuer under subsection (c) after the date of termination of coverage, the report shall contain all information available to the health benefit plan issuer as of the date of the request, including protected health information and the information described in subsection (d), for the thirty-six-month period preceding the date of termination of coverage or for the entire policy period, whichever period is shorter.

(i) No later than thirty (30) days after the date of termination of coverage under a group health plan, a health benefit plan issuer shall provide to the plan, plan sponsor, or plan administrator who makes a request under subsection (c) before the date of termination of coverage a supplemental written report of the information described in subsection (d), including protected health information, to update the report of claim information with information that was not included in the original report.

(j) A plan, plan sponsor, or plan administrator may use information in a written report of claim information provided under this section only as necessary to perform treatment, payment, or healthcare operations as those activities are described in 45 CFR § 164.501.

(k) No health benefit plan issuer that releases information, including protected health information, in accordance with this section shall be deemed to have violated a standard of care, be liable for civil damages, or be subject to criminal prosecution.

(l) This section shall be interpreted so as to be fully consistent with applicable federal law, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d et seq.) and any implementing federal regulations.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it, and applies to written reports of claim information that are requested on or after the effective date of this act.